Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 25, 2025

Licensee
The Sanctuary at West St Paul
1746 Oakdale Avenue
West Saint Paul, MN 55118

RE: Project Number(s) SL32587016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: ______ B. WING ______	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	**1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32587016-0 On November 3, 2025, through November 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 165 residents; 162 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 510		

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0 510	Continued From page 4	0 510		

a large portion or all of the residents).

The findings include:

On November 4, 2025, at 8:42 a.m., the surveyor observed ULP-D prepare R1's medications, gather R1's diabetic supplies and bring them to R1's room along with her breakfast tray. ULP-D put on a pair of gloves, prepared R1's glucometer (device that measures the concentration of glucose (sugar) in a person's blood), wiped R1's right ring finger with an alcohol prep pad, blow on R1's finger, pricked R1's fingertip with a lancet, squeeze R1's finger and placed a drop of blood onto the test strip. ULP-D then administered R1's insulin and mixed Miralax in R1's cranberry juice. ULP-D removed the gloves and immediately put on a new pair of gloves to administer R1's eye drop. ULP-D then removed gloves and administered R1's oral medications. ULP-D did not perform hand hygiene after checking R1's blood sugar or between glove use. ULP-D brought R1's blood sugar supplies back to the medication cart, disposed of the test strip with blood on it and then used hand sanitizer before documenting the administration of medications and blood sugar results.

On November 5, 2025, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated the staff were expected to perform hand hygiene between tasks and in between resident cares.

The licensee's Standard Infection Control Precautions policy dated August 1, 2022, indicated staff would wash hands after touching blood, body fluids, feces, or contaminated items (regardless of whether gloves are worn), before putting on gloves, immediately after gloves or

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0 510	Continued From page 5 gowns are removed and as necessary, between tasks and procedures on the same client to prevent cross-contamination of different body sites, and between all client contacts. Gloves would be worn when touching blood, body fluids, feces, non-intact skin, mucous membranes, or contaminated items. Change gloves between task and procedures on the same client after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, and before touching no-contaminated items, environmental surfaces, self, or other clients. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility.	0 700		

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0 700	Continued From page 6	0 700		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On November 3, 2025, at 12:49 p.m., the surveyor observed a white three ring binder sitting on a table in the common living space in the secured memory care unit. The binder was labeled "Haven Communication Binder". The binder contained resident information which included resident room numbers, resident names, personal health and medication information regarding change in condition and services provided by the staff. The binder was accessible to anyone that was in the common living space.

On November 4, 2025, at 6:48 a.m., the surveyor observed the Haven Communication Binder sitting on a table in the common living space in the secured memory care unit. An unlicensed personnel (ULP) member observed the communication binder at the table and moved it to the cabinet next to the fireplace in memory care. The binder was still accessible to residents or visitors on the cabinet.

On November 5, 2025, at 10:49 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated when the staff were not using the communication binder, it should have been kept in the locked medication

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0 700	Continued From page 7 room, so that it was only accessible to staff. The licensee's Client (resident) Record policy dated August 1, 2021, indicated client (resident) records would contain documents and information to comply with the Minnesota Assisted Living license and other regulatory requirements. The Director of Health Services would identify which staff had access to which documents in the client's (resident) record in order to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 8 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 4, 2025, licensed assisted living director, (LALD)-A and environmental service director, (ESD)-G provided documents on the fire	0 810		

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0 810	Continued From page 9 safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled Fire Safety Policy, dated August 1, 2021, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout, supplied equipment and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Facility had resident procedures in a different policy/plan and will add to the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this	01540		

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01540	Continued From page 10	01540		

initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-D) received the required amount of mental illness, and de-escalation training in the required time frame.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	Continued From page 11 The licensee provided services under an Assisted Living with Dementia Care Facility license. ULP-D was hired on December 23, 2019, to provide direct care and services to the licensee's residents. ULP-D's employee record lacked evidence of completing any mental illness and de-escalation training. On November 5, 2025, at 11:31 a.m., licensed assisted living director (LALD)-A reviewed ULP-D's record and stated she had been assigned the required training; however, had not completed it yet. The licensee's Required Training-Annual/Bi-annual policy dated January 1, 2025, indicated direct-care employees will have a minimum of two (2) hours on training topics related to dementia and one (1) hour on training topics related to mental illness and de-escalation for each twelve (12) months of employment after orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of four residents (R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

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R2 was admitted on April 1, 2019, with diagnoses that included chronic respiratory failure,

On November 3, 2025, at 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2.

R2's service plan dated January 1, 2025, indicated R2 received services to include twice daily vital signs (oxygen saturation and respiratory rate checks).

R2's record lacked documentation of twice daily respiration checks.

R2's record lacked prescriber orders for respiration checks.

On November 5, 2025, at 12:08 p.m., clinical nurse supervisor (CNS)-B reviewed R2's service plan and stated R2 no longer required twice daily respiration checks and the service plan had not been updated. CNS-B stated R2's service plan was now updated and would be reviewed and signed by R2's representative.

The licensee's Service Plan Agreement Development and Revision policy dated August 1, 2021, indicated all assisted living services are provided in accordance with a suitable and up-to-date, written service plan agreement, based on the individual client's (resident) needs and preferences. Each service plan agreement is signed by the RN and the client (resident) and/or the client (resident) representative.

No further information was provided.

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01640	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) assessed one of four	01700		

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resident's (R3) ability to self-administer medications.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3 was admitted on May 27, 2025, with diagnoses that included diabetes.

R3's service plan dated August 20, 2025, indicated R3 received services to include diabetic management and medication administration.

R3's prescriber orders dated May 29, 2025, included the following:
-Insulin Lispro (Humalog Kwikpen) 100 units/milliliter (ml); inject 9 units subcutaneously with lunch and 10 units with dinner.

R3's Basic Assessment dated August 20, 2025, indicated the following:
-Section Medication Management: Does the resident plan to self administer any medications? No
-Section Diabetes Mellitus: insulin injections-indicate level of assistance needed for medication management of insulin injections: licensee ULP insulin Admin (administration) 3 x daily

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On November 3, 2025, at 11:04 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R3's oral medications and Humalog insulin pen for administration. ULP-C brought R3's medications and insulin pen to R3's room. ULP-C administered R3's oral medications and then primed and wasted two units of insulin, dialed the prescribed dose of 9 units, gave the insulin pen to R3 who then self-administered the insulin into her abdomen.

On November 5, 2025, at 10:36 a.m., clinical nurse supervisor (CNS)-B stated she was not aware that R3 self-administered her insulin. CNS-B stated one of the nurses would assess R3's ability to self-administer insulin and if appropriate would update R3's record to reflect self-administration after the ULP prepared the insulin pen.

The licensee's Medication Management Services policy dated August 1, 2021, indicated based on the nursing assessment, the RN (registered nurse) would develop and individualized medication management plan for each client (resident) receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff would provide.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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(a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:
(1) a statement describing the medication management services that will be provided;
(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
(3) documentation of specific resident instructions relating to the administration of medications;
(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
(5) identification of medication management tasks that may be delegated to unlicensed personnel;
(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.

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(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of four residents (R3 and R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3
R3 was admitted on May 27, 2025, with diagnoses that included diabetes.

On November 3, 2025, at 11:04 a.m., the surveyor observed unlicensed personnel (ULP)-C prepare R3's oral medications and Humalog insulin pen for administration. ULP-C brought R3's medications and insulin pen to R3's room. ULP-C administered R3's oral medications and then primed and wasted two units of insulin, dialed the prescribed dose of 9 units, gave the insulin pen to R3 who then self-administered the

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insulin into her abdomen.

R3's service plan dated August 20, 2025, indicated R3 received services to include diabetic management and medication administration.

R3's medication administration record (MAR) dated November 2025, included the following medications:
-aspirin 81 milligrams (mg); one tablet by mouth once daily (heart health)
-bumetanide 2 mg; one tablet by mouth twice daily (edema)
-fluticasone nasal spray 50 micrograms (mcg): one spray in each nostril once daily (allergies)
-Humalog Kwikpen 100 units/milliliter (ml); inject 9 units subcutaneously once daily at noon (diabetes)
-Humalog Kwikpen 100 units/ml; inject 10 units subcutaneously every evening (diabetes)
-Lantus insulin 100 units/ml; inject 28 units subcutaneously every night at bedtime (diabetes)
-metoprolol succinate 25 mg; one tablet by mouth every morning (blood pressure)
-omeprazole 20 mg; one tablet by mouth once daily (acid reflux)
-Ozempic 8 mg/3 ml; Inject 2 mg subcutaneously every 7 days (diabetes)
-psyllium fiber 52 grams; take one capsule by mouth once daily (constipation)
-rosuvastatin 20 mg; one tablet by mouth every night at bedtime (cholesterol)
-sertraline 50 mg; one tablet by mouth once daily (depression)
-spironolactone 25 mg; half tablet by moth once daily (blood pressure)

R3's Basic Assessment dated August 20, 2025, included the following:

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-Section Medication Management: Does the resident plan to self administer any medications? No
-Section Diabetes Mellitus: insulin injections-indicate level of assistance needed for medication management of insulin injections: licensee ULP insulin Admin 3 x daily

R3's Comprehensive Assessment dated August 20, 2025, under the Medication Management section included:
1. Where are medications stored?
D. Medications are kept in a locked medication cart.

R3's medication management plan failed to indicate R3 self-administered her insulin after setup. It further failed to include central storage in the medication room and central storage refrigeration for insulin.

On November 5, 2025, at 10:39 a.m., clinical nurse supervisor (CNS)-B stated R3's medication management plan did not include central storage for medications and did not indicate self-administration of insulin by R3.

R4
R4 was admitted on October 16, 2020, with diagnoses that included diabetes.

R4's service plan dated January 1, 2025, indicated R4 received assistance with medication set-up.

R4's MAR dated November 2025, indicated the following medications were set up by the nurse:
-Certavite Senior; one tablet by mouth every morning (supplement)

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-citalopram 20 mg; one tablet by mouth every morning (depression/anxiety)
-divalproex 500 mg; two tablets by mouth every night at bedtime (bipolar disorder)
-folic acid 400 mcg; one tablet by mouth every night at bedtime (supplement)
-furosemide 40 mg; one tablet by mouth every morning (diuretic)
-glucosamine/chondroitin 500-400 mg; one tablet by mouth every morning (supplement)
-metoprolol succinate 25 mg; one and one-half tablet by mouth every morning (blood pressure)
-niacinamide 500 mg; one tablet by mouth every morning (supplement)
-rosuvastatin 5 mg; one tablet by mouth every night at bedtime (cholesterol)
-tropism 20 mg; one tablet by mouth twice daily (urinary urgency)
-vitamin B-12 1,000 mcg; one tablet by mouth every morning (supplement)
-vitamin C 500 mg; two tablets by mouth every morning (supplement)
-ziprasidone 40 mg; one capsule by mouth twice daily (depression)

R4's Comprehensive Assessment dated October 14, 2025, under the Medication Management section included:
1. Where are medications stored?
B. Resident is independent with medications and storage. Locked storage recommended

On November 5, 2025, at 10:39 a.m., CNS-B stated R4 stored some medications in her apartment; however, the licensee stored R4's medications that they set up in the central storage medication room.

The licensee's Medication Management Services

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01730	Continued From page 22 policy dated August 1, 2021, indicated based on the nursing assessment, the RN will develop an individualized medication management plan for each client (resident) receiving any type of mediation management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01880		

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The findings include:

On November 4, 2025, at 8:40 a.m., the surveyor observed an unattended medication cart unlocked with two insulin pens on the top of the medication cart. Several residents were sitting in the common area where the unlocked medication was located. When unlicensed personnel (ULP)-D returned to the medication cart, she put the two insulin pens away and started to prepare medications for another resident. ULP-D stated the insulin pens should have been put away and the medication cart should have been locked when she stepped away.

On November 5, 2025, at 10:51 a.m., clinical nurse supervisor (CNS)-B stated the medication cart should be locked when not in use, and the insulin pens should have been returned to the appropriate drawer in the medication cart instead of leaving them on the top of the cart.

The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated a nurse must conduct a nursing assessment of a client's (resident) need for medication management services, including the appropriate way to store the client's (resident) medications and whether secured storage is appropriate given the client's (resident) functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the nurse will develop an individualized medication management plan for the client (resident) that will address storage of the client's (resident) medications.

No further information provided.

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01880	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on September 28, 2024, with diagnoses that included diabetes.	01970		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	**1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 25 R1's service plan dated September 25, 2025, indicated R1 received services to include grooming, dressing, bathing, toileting, transfer assistance, bed mobility, escorts, float heels, diabetic management and medication administration. R1's prescriber order dated July 11, 2025, indicated R1 was to wear off loading boots at all times. R1's Service checkoff list dated November 2025, included the following service: -Float heels: float heels on a pillow when in bed. Elevate right heel with a pillow under the calf. When in bed resident needs to have her boot on for heel protection and then float the heels. Unlicensed staff to float resident's heels so that the back of the heel is not touching any surface such as bed/foot rest, etc. On November 5, 2025, at 10:43 a.m., clinical nurse supervisor (CNS)-B stated R1's record lacked an updated prescriber order to wear offloading boots only when in bed. CNS-B stated she would contact R1's primary care provider and request and updated order. The licensee's Medication and Treatment Implementation policy dated August 1, 2021, indicated the RN would update any client (resident) records and service plan as necessary to reflect a new order or prescription. The RN was responsible for assuring that the prescriptions and orders have been implemented appropriately through client (resident) monitoring, supervision of staff and review of client (resident) records. .	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: ______ B. WING ______	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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01970

Continued From page 26

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

02310 SS=F

144G.91 Subd. 4 (a) Appropriate care and services

(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen and refilling of liquid oxygen. This had the potential to affect all residents, staff, and visitors of the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

The licensee held an Assisted Living with Dementia Care license. The facility was licensed for a bed capacity of 174 and had a current census of 165.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED 11/05/2025

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02310	Continued From page 27 On November 4, 2025, during the engineer's survey visit, the engineer observed the following: -four unsecured oxygen cylinders on R6's counter -two unsecured oxygen cylinders on R7's floor -one tank of liquid oxygen in R8's room The licensee failed to ensure R6 and R7's portable oxygen cylinders were stored securely and failed to ensure portable transfilling of liquid oxygen occurred in a safe location away from the resident. On November 5, 2025, at 9:50 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were unaware of the unsecured oxygen cylinders in R6 and R7's room. CNS-B stated all oxygen cylinders should be stored securely. LALD-A stated she already contacted R6 and R7's oxygen supplier to obtain secure holders for the oxygen. LALD-A stated R8 had one liquid oxygen tank in her apartment which she used continuously when in her apartment. LALD-A stated the liquid oxygen tank was used to refill portable oxygen when R8 left her apartment. LALD-A and CNS-B stated they were not aware of the requirements for storing and refilling liquid oxygen. Minnesota Department of Health (MDH) internal document titled, Oxygen Cylinder Storage Requirements dated April 16, 2020, which was based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code states: Storing over 3,000 cubic feet of oxygen - Volumes of 3000 ft^3 and over of oxygen must be	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/05/2025

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02310	Continued From page 28	02310		

stored in special designated rooms that meet the following requirements (storing oxygen in these volumes will require a backup power system and engineer designed ventilation system):
- Sufficient room to maneuver cylinders
- Room able to be secured with lockable doors
- Interior room must be constructed with non-combustible or limited-combustible construction with a minimum fire rating of 1-hour (no allowances for fully sprinklered rooms)
- Be compliant with NFPA 70 National Electric Code with electrical devices protected/located at or above 5 ft above finished floor
- Be heated by indirect means if heat is required
- Be provided with adequate amounts of racks (constructed of non-combustible or limited-combustible materials) and chains to secure all cylinders, full or empty
- A dedicated, continuous-operating mechanical ventilation system that draws air from within 12 inches of the floor, with a means of make-up air provided
- Where natural ventilation is permitted, it shall consist of two louvered openings, each having a minimum free area of 72 in² with one located 12 inches from the floor and one located 12 inches from the Ceiling. NOTE: Louvered natural ventilation openings are not permitted in an exit access corridor.

TRANSFILLING
When a facility uses large containers of liquid oxygen to fill empty portable liquid oxygen containers, this process is called, transfilling. When transfilling activities take place in a facility, the following items must be met to protect staff and residents from the dangers of liquid oxygen:
- the room must be separated by a fire barrier of 1 hour fire resistive construction

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	32587	A. BUILDING: ______ B. WING ______	11/05/2025

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THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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02310	Continued From page 29	02310		

- the area must be mechanically ventilated (negative pressure), sprinklered and have ceramic or concrete flooring
- the room must be posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted
- the individual transfilling must be properly trained in transfilling procedures

MDH Information Bulletin-4-15 Use of Liquid Oxygen dated October 4, 2022, indicated:
Storage of liquid oxygen that is more than the equivalent of 3000 cubic feet:
The requirements for storage of nonflammable gases in quantities greater than 3000 cubic feet can be found in NFPA 99, Sec. 8-3.1.11.1, which requires compliance with Sections 4-3.1.1.2 and 4-3.5.2.2 of NFPA 99. In addition to the requirements outlined in the previous paragraph, such storage locations must be enclosed with construction providing a fire-resistance rating of at least one hour. Such locations shall also be vented to the outside by a dedicated mechanical ventilation system (natural ventilation is allowed where the storage location has at least one exterior wall).

Attachment #1: Locations Used for Transfilling of Liquid Oxygen
This attachment outlines the major requirements that apply to rooms used for the transfer of liquid oxygen from one container to another. The contents herein are based on provisions found in Chapters 4 and 8 of the 1999 edition of NFPA 99 and Chapters 27, 30 and 32 of the 2003 Minnesota State Fire Code.
Such rooms must be completely enclosed with a fire barrier of minimum 1-hour fire resistive construction. This includes:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: ______ B. WING ______	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	**1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118**

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02310	Continued From page 30 Each component of the room (i.e., the floor, all four walls and the ceiling) must have a fire-resistance rating of at least 1 hour. The door into the room must be a listed assembly having a minimum fire resistance rating of 45 minutes. Listed assemblies include the door, frame, and self-closing and positive latching hardware. Flooring must be ceramic or concrete. A concrete floor must be bare. It is not acceptable to paint the concrete floor. The room must be provided with complete automatic sprinkler protection. Depending on the size of the room, one sprinkler head may suffice. The room must be mechanically ventilated as follows: The exhaust fan must provide a minimum of one cubic foot per minute (CFM) of exhaust for each square foot of floor area within the room. For example, a room measuring 36 square feet in area must have a minimum of 36 CFM of exhaust ventilation. Room exhaust and make-up air must be arranged so as to prevent the accumulation of oxygen gas anywhere in the room. To best accomplish this, the exhaust should be located at, or within 6 inches of, the ceiling. Make-up air should be at, or within 6 inches of, the floor. The exhaust system must be dedicated to that room only. It is not acceptable to connect the exhaust fan to any other duct system. The exhaust must go directly to the outside. If the exhaust must go through other areas either adjacent to or above the transfer room, the ductwork must be installed inside of an enclosure with a fire-resistance rating of at least 1 hour. The exhaust fan must operate at all times the transfer of oxygen is taking place. This can best be assured by inter-locking the fan with the room	02310		

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02310	Continued From page 31 lighting. If the room is also used for the storage of oxygen, the exhaust fan must be arranged to operate continuously. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

THE SANCTUARY AT WEST ST PAUL
1746 OAKDALE AVENUE
West St Paul, MN 55118
Dakota County
Parcel:

Phone:
jacques.philippon@fairview.org

License Info

License: HFID 32587

Risk:
License:
Expires on:
CFPM: Jacques Philippon
CFPM #: 41753; Exp: 2/28/2028

Inspection Info

Report Number: F1031251169
Inspection Type: Full - Single
Date: 11/4/2025 Time: 10am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT:
IMMERSION BLENDER FOUND WITH FOOD BUILDUP ON BLADE.
HAD BLENDER SENT TO DISH FOR CLEANING.
CHECK BLADE FOR DEBRIS PRIOR TO USE.
Comply By: Complied On Site Originally Issued On: 11/4/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.11E *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
COMMENT:
OBSERVED A REDDISH SUBSTANCE ON ICE MACHINE BAFFLE.
REMOVE AND CLEAN BAFFLE AND ANY OTHER AREAS INSIDE ICE BIN WHERE DISCOLORATION/IMPURITIES ARE PRESENT.
Comply By: 11/25/2025 Originally Issued On: 11/4/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-303.11A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1470A Provide at least 10 foot candles (108 LUX) of light intensity at a distance of 30 inches from the floor in the walk-in refrigeration units, dry food storage areas, and in other areas during periods of cleaning.
COMMENT:
MEMORY CARE KITCHEN HAS MULTIPLE LIGHTS THAT ARE NOT FUNCTIONAL.
REPAIR/REPLACE LIGHTING.
Comply By: 11/25/2025 Originally Issued On: 11/4/2025

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT:
2 CHEMICAL BOTTLES IN KITCHEN ESTABLISHMENT DID NOT HAVE LABELS.
BOTTLES WERE EMPTIED.
FOLLOW ABOVE DIRECTION.
Comply By: Complied On Site Originally Issued On: 11/4/2025

Food & Beverage General Comment

Establishment has full commercial kitchen.

Discussed all violations with PIC.

Discussed
1. Cooling and reheating
2. Pasteurized eggs and no undercooked meats
3. Illness and illness log
4. Pests

NOTES:
1. Memory Care dish machine is not used. All kitchenware/dishes/utensils are washed in main kitchen.
2. Memory Care to only keep a working stock of butter out.
3. 2 residential refrigerators in memory care kitchenettes are for staff use only.
5. US Foods (distributor)

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031251169 from 11/4/2025

Jacques Philippon
Exec. Chef

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info
THE SANCTUARY AT WEST ST PAUL
West St Paul
County/Group: Dakota County

Inspection Info
Report Number: F1031251169
Inspection Type: Full
Date: 11/4/2025
Time: 10am

Food Temperature: **Product/Item/Unit:** Ham; **Temperature Process:** Hot-Holding
Location: Steam Table at 160 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Ham; **Temperature Process:** Cold-Holding
Location: Prep Table (top) at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Hot Dogs; **Temperature Process:** Cold-Holding
Location: Prep Table (bottom) at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Dressing; **Temperature Process:** Cold-Holding
Location: 2-Door Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Ck Noodle Soup; **Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Zupa Toscana; **Temperature Process:** Re-Heating
Location: Steamer at 193 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Milk; **Temperature Process:** Cold-Holding
Location: 1-Door Cooler (memory care kitchen) at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info
THE SANCTUARY AT WEST ST PAUL
West St Paul
County/Group: Dakota County

Inspection Info
Report Number: F1031251169
Inspection Type: Full
Date: 11/4/2025
Time: 10am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 173 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dish Machine
Location: 3-Comp Sink **Equal To** 300 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 200 PPM
Comment:
Violation Issued?: No